



**AGENCY ADMIN. & FINANCE**

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**Health Program of Alameda County Application Workflow**

One-e-App enrolls and is the system of record for the Health Program of Alameda County ("HealthPAC").

To participate in the HealthPAC program, applicants must meet the following qualifications:

- Must have income at or below 200% of the Federal Poverty Level
- Must be a resident of Alameda County
- Must be able to provide proof of identity, proof of Alameda County Residency, and proof of income
- Applicants must be between the ages of 19 and 64 years of age
- For the MCE and HCCI Programs must be a US Citizen or a Legal Resident (for 5 years) and be able to provide proof of citizenship
- For the MCE and HCCI Programs must not have linkage to Medi-Cal, AIM or Healthy Families

The following pages will outline in a general way the screens and workflow in One-e-App:

## A Typical HealthPAC Application for a single male

The screenshot shows the 'oneeapp' logo with the tagline 'One Stop Access to Health Care'. The navigation bar includes 'step 1: getting started' and 'help exit'. Language options 'English' and 'Español' are available, with 'Alameda County' selected. The main heading is 'Consent to Share Information'. The text explains that provided information will be used to determine eligibility for health care services and may be submitted to benefit plans. It also states that if the user does not agree to share information, they will not be collected electronically and may need to complete paper applications. A list of agencies and organizations that may share the information is provided: Alameda County Health Care Services Agency, Alameda County Social Services Agency, Alameda County Medical Centers, The Community-Based Health Clinic network, Healthy Families, Medi-Cal, Alameda County Alliance For Health, and Kaiser Permanente. A note mentions that these agencies may be required to share information with other agencies not listed. At the bottom, there is a question: 'Do you agree to share your personal information with the agencies and organizations listed above in order to determine your eligibility and to apply for benefits for you and members of your household?' with 'Yes' selected. Navigation buttons for 'Print', 'Languages', and 'Next' are at the bottom.

**oneeapp**  
One Stop Access to Health Care

step 1: getting started help exit

English Español Alameda County

### Consent to Share Information

The information you provide will be used to help determine if you or someone in your household qualifies for one or more benefit plans that can pay for health care services. The information you provide may, upon your approval, be submitted to these benefit plans to apply for health care coverage.

If you do not agree to share your information, your personal information will not be collected electronically. You may still complete separate paper applications for any benefit plan for which a paper application exists. If a plan does not have a paper application and you do not agree to share your information, you will not be considered for benefits from that plan, and it is possible that you will not receive benefits for which you qualify.

Your information may be shared with these agencies and organizations:

- Alameda County Health Care Services Agency
- Alameda County Social Services Agency
- Alameda County Medical Centers
- The Community-Based Health Clinic network that contracts with Alameda County to provide health care
- Healthy Families
- Medi-Cal
- Alameda County Alliance For Health
- Kaiser Permanente

These agencies may be required to share your personal information with other agencies or organizations not listed here in order to process your application or perform business functions related to the administration of these benefit plans.

Do you agree to share your personal information with the agencies and organizations listed above in order to determine your eligibility and to apply for benefits for you and members of your household? ☒ Yes ☐ No


Print Languages Next

### Screen 1: Consent to Share Information

This screen documents the agencies with whom the main data may be shared

The document uses the following scenario

- A single adult male is the Primary Informant, sole applicant and is a US Citizen

**Tell us about yourself** **Notes**

---

Are you a member of the household? ☒ Yes ☐ No

**First Name**  **Middle Name**  ☐ None **Last Name**  **Suffix**

Was this your name at birth? ☒ Yes ☐ No **Mother's Maiden Name**  ☐ Unknown **Do you use any other names?** ☐ Yes ☒ No

**How would you like to be contacted?**  **Email**

**Home Phone**    **Cell Phone**    **Work Phone**     **Message/Emergency Phone**


**What language do you speak best?**  **What language do you read best?**

**Homeless** ☐ Yes ☒ No **Are home and mailing address the same?** ☒ Yes ☐ No

**Home Address (do not use PO Box)**

**Delivery Type**  **Street Number**  **Prefix**  **Street Name**  **ST** **Post Direction**  **Unit Type and Number**


**City**  **State**  **Zip**   **County**

 **Verify**

**Mailing Address**

**Delivery Type**  **Street Number**  **Prefix**  **Street Name**  **Suffix**  **Post Direction**  **Unit Type and Number**

**City**  **State**  **Zip**   **County**

 **Verify**

**Screen 2: Tell us about yourself****Demographics Screen for Primary Informant and household address/contact information**

11/18/2011

3

English **Español** Alameda County

**Representative:** [Sample S Male](#)

**Tell us more about Sample S Male**  **Notes**

Is this person applying for health care coverage? ☒ Yes ☐ No

Gender ☒ Male ☐ Female

Date of Birth    

Place of Birth *(Select first ONE that applies)*

California County  or

US State  or

Other Country

Ethnicity

Marital Status

Spouse's First Name

Spouse's Middle Name  ☐ None

Spouse's Last Name

Suffix

**Next**

**Screen 3: Tell us more about applicant – Indicates the applicant is seeking coverage and captures important demographics**

English **Español** Alameda County

**Adult(s):** [Sample S Male](#)

**Tell us more about Sample S Male**  **Notes**

Does Sample S Male have a physical, mental or emotional disability? ☐ Yes ☒ No

Has Sample S Male ever received Cash Aid, SSI, Food Stamps or Medi-Cal? ☐ Yes ☒ No

Does Sample S Male work more than 100 hours a month? ☐ Yes ☒ No

Is Sample S Male living in a Long Term Care facility? ☐ Yes ☒ No

Is Sample S Male living in a Board and Care facility? ☐ Yes ☒ No

**Next**

**Screen 4: Tell us more about Applicant - This includes screening Medi-Cal linkage questions – if an applicant links to Medi-Cal it will be primarily due to a Yes response on this screen. Applicants eligible for Medi-Cal will be forwarded to Alameda County Social Services Agency for final disposition.**

Adult(s): Sample S Male

Tell us more about Sample S Male

Notes

Is Sample S Male currently enrolled in any public benefit program(s)? ☐ Yes ☒ No

Does Sample S Male have a pending Medi-Cal application? ☐ Yes ☒ No

Has Sample S Male been denied for Medi-Cal? ☐ Yes ☒ No

Does Sample S Male have other health insurance? ☐ Yes ☒ No

Does Sample S Male have other Vision or Dental insurance? ☐ Yes ☒ No

Does Sample S Male currently have employer paid insurance? ☐ Yes covered Now  
☐ Not Now, but during the past 90 days  
☒ No

Are there any more persons in the household? ☐ Yes ☒ No

Next

**Screen 5: Tell us more about Applicant (Insurance Screen) -This screen determines linkage to both public health programs like Medi-Cal, AIM, Healthy Families and other insurance programs that might impact eligibility for the HealthPAC Program.**

**If there were more members in the household this is also the screen that cues One-e-App would ask the same questions of the other household members.**

**Household Summary**

Please make any necessary changes.

To remove a person from the application, check the box next to that person's name and click the 'Remove' button below.

Name	Applying for coverage	Child Living in Household	Remove
Sample S Male (P1)*	Yes		

Do all the persons in this application purchase and prepare food together? ☐ Yes ☐ No

A food stamps household is a group of persons who share food together. Please indicate which persons share food together in the table below.

 **Add Food Stamp Group** **Remove Food Stamp Group**

\* Applying for coverage

\*\* Please select the individual who is financially responsible for this child

To add additional household members to the application, answer Yes to the following question and click Next

Are there any more persons in the household? ☐ Yes ☒ No

**Next**

**Screen 6: Household Summary Screen – gives an overview of the household structure.**

**Please Note:** If the applicant was a woman of childbearing age the next screen would ask about pregnancy. If the applicant was pregnant the linkage to Medi-Cal would screen the applicant out of HealthPAC MCE and HCCI

## One-e-App Person Clearance



Please review the results of the One-e-App person clearance and indicate whether the person has used One-e-App to apply for health care assistance programs. If you select a name below, the associated Person ID will be applied to the individual in this application.



### Re-run Person Clearance with Expanded Search

The system has run person clearance by using the default parameters. If you cannot find one or more persons on the application and believe that they should exist in the system, please click the above button to rerun the person clearance search with the expanded search criteria.

#### Sample S Male

Score	Person Name	Person ID	Current Application ID	Date Of Birth	Place Of Birth	Gender
No matching records were found.						

The person is not known to One-e-App

**Note:** Rows that are highlighted in blue, indicates that the person is a potential match based on SSN and/or address and other household members.

Next

English

Español

Alameda County

## Household Person Details



Person details for the application are summarized below.

#### Adult(s)

Name	Date of Birth	Person ID	Applying for Coverage
Sample S Male	1/1/1970	30100001321118	Yes

Next

**Screens 7 & 8: One-e-App Person Clearance – One-e-App needs to assign a unique identifier and performs a search against the database of existing applicants that insures that duplicates are not created in the database.**

**Once that search has been completed and no matches found, One-e-App assigns a unique identifier that will be used for HealthPAC Cards and reporting purposes going forward.**

## Tell us about Sample S Male's Income



Income Type	Frequency	Amount	Gross Monthly Amount
Earnings from job ▼	Monthly ▼	\$1,500.00	\$1,500.00

Date Received/Expected to be Received 10 31 2011

Pay Period Begin Date 10 01 2011

Income Terminated ☐ Yes ☒ No

Does Sample S Male have any more income? ☐ Yes ☒ No

Next

## Sample S Male's Care Expenses



Please enter any care expenses or support payments paid by Sample S Male

Person Cared For	Care Expenses	Frequency	Amount Paid
Not in household ▼	Child Support ▼	Monthly ▼	\$250.00

Gross amount billed to Sample S Male is \$ 250.00

Court order number F233209348

### Person Cared For

First Name Baby

Middle Name L

Last Name Sample

Suffix ---Select One--- ▼

Date of Birth 11 12 2007

Does Sample S Male have any more expenses? ☐ Yes ☒ No

Next

**Screens 9 & 10: Household Income and Expenses – One-e-App captures the income and expense data from the applicant and uses this data to calculate eligibility (family size/age of applicant/income/expenses)**



English
Español

Alameda County

Additional Household Information

Notes

Has anyone filed a lawsuit because of an accident or injury on behalf of anyone listed on the application?
☐ Yes
☒ No

Does anyone listed on the application want to apply for Medi-Cal coverage for any unpaid expenses in the last 3 months?
☐ Yes
☒ No

Is there more than one car in the household of those you are applying for?
☐ Yes
☒ No

Does anyone listed on this application have a savings or checking accounts?
☒ Yes
☐ No

Does any person listed on this application have a physical, mental, emotional or developmental disability?
☐ Yes
☒ No

Next

Screen 11: Additional Household Information – this finishes up the questions required for the Medi-Cal application

English
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Alameda County

Potential Eligibility for Additional Programs

Notes

You or members of your household may be potentially eligible for the programs in the table below. Eligibility will be based on the additional information you provide.

Potential Eligibility for Programs	
Person Name	Program Name
Sample S Male	HealthPAC

Next

Screen 12: Potential Eligibility for Additional Programs (First Calculate) - The results of the first calculation are displayed on this screen. Applicants can be determined preliminarily eligible for multiple programs. This applicant did not qualify for Medi-Cal and is preliminarily eligible for HealthPAC, the local indigent program. Citizenship must be entered to determine the correct program within HealthPAC.

**Additional Information**



The following additional information is needed as indicated. Please note that applicants will be able to "opt out" of applying for this program once the preliminary eligibility has been determined.

**Sample S Male**U.S. Citizen or National (Optional) ☒ Yes ☐ NoLegal Resident ☐ Yes ☐ NoDate Legal Permanent Status Received   Prucol Alien ☐ Yes ☐ NoDate of Entry to U.S.   SSN   

**Screen 13: Additional Information (Citizenship)** – since the applicant indicated that he was born in California, One-e-App defaults the answer to U.S. Citizen or National. The Social Security Number is also captured on this screen. All responses on the screen are optional.

**Preliminary Eligibility Results** **Notes**

Based on the information you have provided, the following persons in your household may be eligible for the following programs.

Preliminary Eligibility for Programs				
Opt Out	Person Name	Program Name	Coverage Type	BRM
	Sample S Male	HealthPAC	Primary	

Your family is also eligible for \$100 cash back for home internet service. Please click on the "learn more" link below for more information.

Cash Back Program to Get Internet at Home		
Person Name	Service	More Information
Sample S Male	Cash Back for Home Internet	<a href="#">Learn More</a>


Note: BRM stands for Birth Records Match Status.



Please click on this icon to see the explanation of the icons shown in the "BRM" column.

**Next** 

**Screen 14: Preliminary Eligibility Results (Final Eligibility) and Birth Record Match** – Once the citizenship details have been completed then the final eligibility results are displayed.

A  in the BRM column indicates that the applicant can be matched to the California Birth Record Match database which appears in a separate window. Applicants can also submit other forms of original documentation that supports their citizenship (i.e. birth certificate, passport, etc.)

English
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Alameda County

One-e-App Reconsider Referral

Notes

Application ID: 201132100011  
Representative Name: Sample S Male

One-e-App is a preliminary eligibility system. It indicates the person(s) on this application are not likely to be eligible for one or more programs. Since this is not a final eligibility determination, you may still submit your electronic application for the program(s). Please identify the person(s) and the program(s) below for which you would like to submit the application.

Override	Person Name	Program Name
<input type="checkbox"/>	Sample S Male	<input type="checkbox"/> Medi-Cal

Next

**Screen 15: One-e-App Reconsider Referral:** Even though this applicant did not qualify for Medi-Cal this universal application system gives him the opportunity to override this decision and apply anyway. Most applicants accept the One-e-App determination of eligibility coverage.

English
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Alameda County

Signature Option

Notes

Please select a method for submitting your signature from the options below.

☒ I have an electronic signature tablet with which I will submit signatures.
   
☐ I will print the Rights and Declarations page(s) and either fax or scan them using the document cover sheet provided at the end of the application process.

Next

**Screen 16: One-e-App** allows users to choose to capture applicant signatures electronically or on paper. Most users utilize the electronic version as it reduces paper waste and is retained in the system permanently.

English
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Alameda County

HealthPAC Verification Documents
Notes

Please check the box next to each document you have seen.

**Sample S Male**

☒ Proof of Income

Verification
Received
Source
Paystub

☒ Proof of Alameda County Residency

Verification
Received
Source
Unemployment benefits statement

☒ Proof of Identification

Verification
Received
Source
Driver's License or ID

☒ Proof of Citizenship or Legal Permanent Residency

Verification
Received
Source
U.S. Birth Certificate

Upload Document
Next

**Screen 17: HealthPAC Document Verification – Applicants must provide proof of eligibility for HealthPAC. These support documents can be uploaded for audit verification via the “Upload Document” button**

English
Español
Alameda County

HealthPAC Provider Selection
Notes

**Sample S Male**

Select a Provider
LifeLong Medical Care
Select a Home Clinic
Berkeley Primary Care

Medical Home Change History
Next

**Screen 18: HealthPAC Medical Home**

**This is the page that the applicant chooses their HealthPAC Medical Home**

## HealthPAC Rights and Declarations



**Application ID:** 201132100011  
**Representative Name:** Sample S Male

**I, Sample S Male, am eligible for the HealthPAC program. I have read and agree to the following for myself and household members eligible for the HealthPAC program:**

1. I am a now a resident of Alameda County.
2. I am not now enrolled in the Medi-Cal program. If I am found to be enrolled in Medi-Cal during my term, I will be disenrolled from HealthPAC.
3. I know that HealthPAC is not an insurance program and is only valid at contracted HealthPAC providers for non-emergency services. If I get care outside of the HealthPAC Provider network for non-emergency services, I know that I must pay for the care.
4. I know that I may be disenrolled for the reasons stated in the HealthPAC Participant Handbook.
5. I know that my eligibility will be checked each year and that I must complete a yearly redetermination to stay in HealthPAC.
6. I agree to call HealthPAC Customer Service to disenroll from HealthPAC if I move out of Alameda County.
7. If I am asked to apply for any other public coverage program, I must do so. If I refuse to apply for a public coverage program when asked to, I may be disenrolled from HealthPAC and may have to pay for my care.
8. I know that if the information I give as part of my application is found to be fraudulent or misleading, I will be disenrolled and may be billed for all services that were covered under the HealthPAC program.
9. I approve release of my information for billing and the assignment of health services benefits.
10. I know that I can file a complaint within 60 days of the event giving rise to the complaint by calling **HealthPAC Customer Service: 1-877-879-9633.**
11. I know that I can file an appeal in response to a Notice of Action from HealthPAC about an eligibility or service authorization within 60 days by calling HealthPAC Customer Service at 1-877-879-9633. If I do not agree with how this appeal is resolved, I may have a right to a State Fair Hearing.
12. I know that by signing my name to this form, I agree to contact by HealthPAC or Alameda Alliance for Health for enrollee surveys or focus groups at the mailing address and/or phone number in this application. Taking part in these is my choice.

I have read this form and have been given the chance to discuss the items above with an application assistor. I declare that the above is true and correct. Further, by signing below, I authorize County staff, agents or contractors to check my eligibility.

**Applicant's Signature:**

Sign  
 Save  
 Clear

**Witness Signature:**

Sign  
 Save  
 Clear

**Screen 19: HealthPAC Rights and Declarations – applicants must sign the HealthPAC declaration and consent to complete the application.**



## **Participant's Guide to the Grievance and Appeal Process**

### **Complaints and Problems:**

Your satisfaction is important to us! If you have a problem with HealthPAC, you have the right to make a complaint. This is also called filing an appeal or a grievance. An appeal is when you ask for review of an "action." Actions are:

- A denial, termination or reduction of eligibility for HealthPAC
- A denial or limited authorization of a requested service
- A reduction, suspension, or termination of a previously authorized service
- A failure to provide services in a timely manner
- A failure of HealthPAC or the State to act within the timeframes for grievances and appeals

Anything other than an appeal is usually called a grievance.

If you are successfully enrolled in the program, you will get a HealthPAC Participant Handbook and a HealthPAC ID card. If you apply for HealthPAC and are denied, you will be sent a notice. If you would like to appeal a denial, termination or reduction of eligibility for HealthPAC, or have a problem with your health care services or benefits, you can call **HealthPAC Customer Service: 1-877-879-9633**. We want to help you.

If you have a grievance or appeal, you may file it by phone or by filling out a grievance form. You can contact us at 1-877-879-9633. Callers who are deaf or hard of hearing may use the California Relay Service by dialing 7-1-1. You can also send a letter that describes your complaint to:

**Fax: (510) 747-4522**

or

**Attn: HealthPAC Grievances & Appeals  
Alameda County Health Care Services Agency  
1000 San Leandro Blvd, Suite 300  
San Leandro, CA 94577**

You will be treated with respect during the HealthPAC grievance and appeal process. You have the right to give your views or propose a solution. You may speak for yourself or have someone else speak for you. You may ask to look at our records in connection with your grievance or appeal.

### **Timeframes:**

If you are enrolled in HealthPAC, you will be mailed a notice at least 10 calendar days before a termination or reduction in service.

**If you have a problem, you must file a grievance with HealthPAC within 60 calendar days of the event giving rise to the grievance. You must file an appeal of an action within 60 calendar days of the date of the Notice of Action.**

HealthPAC Customer Service will review your grievance or appeal and send you a response within **45 calendar days**. If you think that waiting 45 days will harm your health, be sure to say why when you file your grievance. Then you might be able to get an answer within **3 working days**.

### **Continuation of Benefits:**

If you submit an appeal or grievance, your benefits will continue until one of the following:

- You withdraw the appeal.
- Ten calendar days pass after a Notice of Resolution that denies your appeal is sent to you, unless you ask for a State Fair Hearing with continued benefits within **10 calendar days** of when the appeal decision is issued.
- A State Fair Hearing decision against your appeal is issued.

**Screen 20: HealthPAC Grievance and Appeals – applicants will receive a copy of their rights under the HealthPAC Grievance and Appeals Process**

English
Español

Alameda County

Receipt of Citizenship or Identity Documents

Notes

Check the box below if you want to provide proof of Identity and Citizenship for any of the following individuals?

**Sample S Male** ☒

	Document	Original/Copy	Received
Citizenship	U.S. Citizen I.D. Card (Form I-197 or I-179)	Original	In person - Applicant/Beneficiary Name: Sample S Male
Identity	Driver's License issued by State or Territory	Original	In person - Applicant/Beneficiary Name:

**For System Use**  
Please enter the date the Receipt of Citizenship or Identity Documents was signed.
11
18
2011

Print DHCS 0005
Next

State of California – Health and Human Services Agency Department of Health Care Services

### Receipt of Citizenship or Identity Documents

**Instructions to County/DSH/FQHC Staff:** When you receive citizenship and/or identity document(s) for an applicant or beneficiary, you must fill out this form.

Citizenship/Identity document for Applicant or Beneficiary:

Sample S Male Date of birth: 01/01/1970

Address: 111 Main ST San Leandro CA 94577

Name of parent if Applicant or Beneficiary is a child:

Applicant or Beneficiary BIC/CIN:

<p>Name of the citizenship/identity document you saw:</p> <p>U.S. Citizen I.D. Card (Form I-197 or I-179)</p> <p>The document you saw was (check one):</p> <p><input checked="" type="checkbox"/> An original (not a photocopy or a notarized copy)</p> <p><input type="checkbox"/> A copy that was certified by the issuing agency</p> <p>This document was received (check one):</p> <p><input type="checkbox"/> By mail</p> <p><input checked="" type="checkbox"/> In person (from the applicant or beneficiary)</p> <p>Name: Sample S Male</p> <p><input type="checkbox"/> In person (from a guardian, authorized representative, or caretaker relative)</p> <p>(Name and relationship to applicant or beneficiary)</p>	<p>Name of the citizenship/identity document you saw:</p> <p>Driver's License issued by State or Territory</p> <p>The document you saw was (check one):</p> <p><input checked="" type="checkbox"/> An original (not a photocopy or a notarized copy)</p> <p><input type="checkbox"/> A copy that was certified by the issuing agency</p> <p>This document was received (check one):</p> <p><input type="checkbox"/> By mail</p> <p><input checked="" type="checkbox"/> In person (from the applicant or beneficiary)</p> <p>Name:</p> <p><input type="checkbox"/> In person (from a guardian, authorized representative, or caretaker relative)</p> <p>(Name and relationship to applicant or beneficiary)</p>
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Make a photocopy of the citizenship and/or identity document received from the applicant or beneficiary, return the original document(s) to the bearer and provide a copy of the signed receipt to the bearer. Once the document is received by the eligibility worker, the county social services office will notify the applicant or beneficiary of this receipt if the document(s) provided are acceptable. DSH/FQHC staff must send this receipt and copies of the document(s) to the appropriate county social services office.

County/DSH/FQHC Staff reads and signs below.

I declare under penalty of perjury under the laws of the State of California that the information above is true and correct.

Signature of County/DSH/FQHC Staff: Caa Traineeone Date:

Name of County/DSH/FQHC Staff (print): Caa Traineeone

Information: Alameda County Behavioral Health Care Services (510) 618-1996 sameena.shah@aacgov.org

Name of agency County Telephone number E-mail

County fills out this box	
Case No:	Case Name:

DHCS 0005 (02/08)

Page 1 of 1


**Screens 21 & 22: Receipt of Citizenship or Identity Documents (DHCS 0005) – on this screen users must verify that they have seen original documents that support the citizenship and identity of the applicant eligible for HealthPAC. This will be stored electronically as a completed and signed PDF.**



## HealthPAC Application Submission





You are able to submit this application at this time to HealthPAC. Please ensure you have collected and faxed all of the verification documents required for this program.


<div><input type="checkbox"/> 201132100011</div>					
	Person	Status	Program	Coverage	Program Summary
	Sample S Male	Referred	HealthPAC	Primary	N/A


**PLEASE NOTE:** If you choose not to submit this application to Health-e-App for the Healthy Families program, persons eligible for the program will not be given a slot on the waitlist. It is highly recommended that you submit all persons qualified for Healthy Families as soon as possible. If you suspend this application without submitting to Health-e-App a communication will be sent to your supervisor and this application will be reported on the incomplete submission list.

**IMPORTANT:** Please remember to fax the verification documents to One-e-App using the One-e-App Fax Coversheet.

Note: Each  Indicates that the application is ready to be transferred to .

Note: Each  Indicates that the application is not ready to be transferred to .

Note: Each  Indicates that the person's information is complete.

Note: Each  Indicates that the person's information is incomplete.

[Generate Fax Cover](#)[Print](#)[Languages](#)[Submit](#)[Upload Document](#)

**Screen 23: HealthPAC Application Submission – Fax cover sheets can also be generated to scan applicant verification documents and then are referred to the Audit Workload for review and compliance with HealthPAC Program rules including verification of faxed documents (Proof of Identity, Proof of Alameda County Residency, Proof of Income, and Proof of Citizenship.)**

English
Español
Alameda County

### Welcome Letter

**Application ID:** 201132100011

Dear Sample S Male

These Members of your family have been determined preliminarily eligible for the following programs and have submitted for approval.

Program Name	Person Name
HealthPAC	Sample S Male

If any of the boxes below have been checked you should bring a copy of that documents to ensure approval into this program.

Program Name	Document Name	Eligible Persons
No matching records were found.		

If you have any questions, please do not hesitate to contact me.

Caa Traineeone  
Behavioral Health Care Services  
Phone Num:(510)618-1996

Print
Next

**Screen 24: HealthPAC Welcome Letter** – this screen can be printed and given to the applicant to remind them to bring in missing documentation and give them a number and name of a person to contact for follow-up

English
Español
Alameda County

### Submitted

Notes

You have completed the application process. Your One-e-App Application ID is: **201132100011**. Your current program status is:

Person ID	Person Name	Program Name	Status
30100001321118	Sample S Male	HealthPAC	Completed

Please note: Further documentation may be required to complete enrollment.

Click the Next button to return to the 'Menu' screen.

Print
Languages
Upload Document
Next

**Screen 25: Submission Screen**– this screen confirms submission to the Audit workload for review and approval

## The HealthPAC Approval Process

The screenshot shows the 'oneeapp' logo with the tagline 'One Stop Access to Health Care' in the top left. In the top right, there are links for 'help' and 'exit', and a 'Menu' button. The main heading is 'HealthPAC Audit Workload'. Below this, there are several input fields and dropdown menus: 'Application ID', 'Person ID', 'Applicant First Name', 'Applicant Last Name', 'Program Name' (with a dropdown arrow), 'Organization' (with a dropdown arrow), 'Location' (with a dropdown arrow), and 'Assistor' (with a dropdown arrow). Below these fields is a section titled 'Application Submission Date Range' in red. It contains 'From' and 'To' labels, each followed by three input boxes and a calendar icon. At the bottom left, there are 'Search' and 'Reset' buttons.

**Screen 26: HealthPAC Audit Workload** –Once the user clicks submit, the HealthPAC application will be routed to a HealthPAC Auditor who will review the application for compliance with the program rules. They will find this application in the HealthPAC Audit Workload immediately after submission. The HealthPAC Auditor will click on the application they wish to audit.

## Application Submission Details



Application ID: **201132100011**

Date Submitted: **11/18/2011**

Primary Informant: **Sample Male**  
 Address: **111 Main ST, San Leandro, CA, 94577**  
 Phone: (H): **510-555-5555**

## Income Details

Person Name	Income Type	Gross Monthly Amount
Sample Male	Earnings from job	\$1,500.00

## Preliminary Eligibility for Programs

Opt Out	Person ID	Person Name	DOB	SSN	Program Name	Coverage Type
<input type="checkbox"/>	<u>30100001321118</u>	Sample S Male	01/01/1970		HealthPAC	Primary

## Application Data

Program Name	Person Name	Application Status
HealthPAC	Sample S Male	Completed

## Follow-up

App ID	Person ID	Person Name	Program Name	Returned By	Returned Reason	Comments
No matching records were found.						

Disposition Details									
	Person Name	Program Name	Disposition	Disposition Date	Coverage Type	Denial Reason	Coverage Period	Share of Cost Amount	Comments
▶	Male, Sample S	HealthPAC (HCCI)		11/18/2011	Primary	N/A	11/01/2011 - 10/31/2012	N/A	<u>N/A</u>

## Verification Documents

**Temporary Verification Documents** No verification documents have been received.

**Permanent Verification Documents** No verification documents have been received.

**Additional Temporary Verification Documents-1** No verification documents have been received.

**Additional Temporary Verification Documents-2** No verification documents have been received.

**Additional Temporary Verification Documents-3** No verification documents have been received.

**Screen 27: HealthPAC Disposition Details** – The auditor can verify all of the application details to confirm that the applicant has been compliant with all HealthPAC Program rules.

oneeapp

One Stop Access to Health Care

HealthPAC Approval Declaration

Application ID:201116400056

Representative Name:

HealthPAC Audit Approval

This certifies that I have reviewed and approved this application based on the HealthPAC Program Rules.

Disposition status :

Approved

Reason for change:

Applicant's Signature:

6/15/2011 1:21:20 PM

Sign

Save

Clear

Signature Date (Only required if not electronically signed):

Print

Approve

Generate Universal Summary

Screen 28: HealthPAC Approval Declaration – Once the Auditor has verified that the applicant has been compliant with all HealthPAC Program rules the application can be signed, approved and forwarded back to the Alameda Alliance for HealthPAC Card generation.

11/18/2011

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